HOUSE BILL No. 1627

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-8-10.

Synopsis: Coverage for employees with chronic conditions. Provides for automatic eligibility for coverage under a comprehensive health insurance association policy for certain individuals with certain chronic conditions. Specifies premium payment requirements.

Effective: July 1, 2007.

Tyler

January 23, 2007, read first time and referred to Committee on Insurance.

Introduced

First Regular Session 115th General Assembly (2007)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2006 Regular Session of the General Assembly.

HOUSE BILL No. 1627

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-10-5.1, AS AMENDED BY P.L.211-2005, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 5.1. (a) A person is not eligible for an association policy if the person is eligible for Medicaid. A person other than a federally eligible individual may not apply for an association policy unless the person has applied for Medicaid not more than sixty (60) days before applying for the association policy.

(b) Except as provided in subsection (c), a person is not eligible for an association policy if, at the effective date of coverage, the person has or is eligible for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana as set forth in IC 27. However, an offer of coverage described in IC 27-8-5-2.5(e), IC 27-8-5-2.7, IC 27-8-5-19.2(e), or IC 27-8-5-19.3 does not affect an individual's eligibility for an association policy under this subsection. Coverage under any association policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

(c) Except as provided in IC 27-13-16-4 and subsection (a), a person is eligible for an association policy upon a showing that:

(1) the person has been rejected by one (1) carrier for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana, as set forth in IC 27, without material underwriting restrictions;

(2) an insurer has refused to issue insurance except at a rate exceeding the association plan rate; ~~or~~

(3) the person is a federally eligible individual; **or**

(4) the person:

(A) is employed for at least twenty (20) hours per week; and

(B) has a chronic condition specified in section 5.2(b) of this chapter.

For the purposes of this subsection, eligibility for Medicare coverage does not disqualify a person who is less than sixty-five (65) years of age from eligibility for an association policy.

(d) Coverage under an association policy terminates as follows:

(1) On the first date on which an insured is no longer a resident of Indiana.

(2) On the date on which an insured requests cancellation of the association policy.

(3) On the date of the death of an insured.

(4) At the end of the policy period for which the premium has been paid.

(5) On the first date on which the insured no longer meets the eligibility requirements under this section.

(e) An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not operate to terminate a dependent unmarried child's coverage while the dependent is and continues to be both:

(1) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

(2) chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, and subsequently as may be required by

the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(f) An association policy that provides coverage for a family member of the person in whose name the contract is issued must, as to the family member's coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children must consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium must be furnished to the carrier within thirty-one (31) days after the date of birth in order to have the coverage continued beyond the thirty-one (31) day period.

(g) Except as provided in subsection (h), an association policy may contain provisions under which coverage is excluded during a period of three (3) months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of three (3) months before the effective date of coverage. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(h) If a person applies for an association policy within six (6) months after termination of the person's coverage under a health insurance arrangement and the person meets the eligibility requirements of subsection (c), then an association policy may not contain provisions under which:

(1) coverage as to a given individual is delayed to a date after the effective date or excluded from the policy; or

(2) coverage as to a given condition is denied;

on the basis of a preexisting health condition. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(i) For purposes of this section, coverage under a health insurance arrangement includes, but is not limited to, coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.

SECTION 2. IC 27-8-10-5.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 5.2. (a) This section applies to an individual who is employed for at least twenty (20) hours per week.**

(b) The following chronic conditions are cause for automatic

eligibility for an association policy for an individual described in subsection (a), as provided in section 5.1(c)(4) of this chapter:

(1) Artificial heart valve.
(2) Bronchopulmonary dysplasia.
(3) Cardiomyopathy.
(4) Cerebral palsy.
(5) Chronic obstructive pulmonary disease.
(6) Cirrhosis of the liver.
(7) Crohn's disease.
(8) Cystic fibrosis.
(9) Dermatomyositis.
(10) Epilepsy.
(11) Hemochromatosis.
(12) Hemophilia.
(13) Hepatitis B or hepatitis C.
(14) Human immunodeficiency virus (HIV), including acquired immune deficiency syndrome (AIDS).
(15) Hydrocephalus.
(16) Insulin dependent diabetes mellitus.
(17) Kidney transplant (within twenty-four (24) months).
(18) Lead poisoning with cerebral involvement.
(19) Leukemia.
(20) Lupus erythematosis.
(21) Malignant tumor (within four (4) years).
(22) Multiple sclerosis, including disseminated sclerosis.
(23) Muscular dystrophy.
(24) Myasthenia gravis.
(25) Myocardial infarction (within two (2) years).
(26) Paraplegia or quadriplegia.
(27) Pernicious anemia.
(28) Polyarteritis.
(29) Scoliosis.
(30) Sickle cell anemia.
(31) Splenic anemia.
(32) Still's disease.
(33) Syphilis of the cardiovascular system.
(34) Tabes dorsalis.
(35) Thalassemia.
(36) Topectomy and lobotomy.
(37) Ventilator dependency.
(38) Another chronic condition determined by the board to be of sufficient severity to cause the individual to be

automatically eligible for coverage under an association policy.

(c) An employer that provides a group health plan for the employer's employees may refer an employee described in subsection (a) who has a chronic condition specified in subsection (b) to the association for coverage under an association policy rather than under the group health plan if the employer pays one hundred percent (100%) of the employee's premium for the association policy.

(d) This subsection does not apply to an insured who is an employee referred to the association for coverage under subsection (c). The premium for an association policy issued to an employee described in subsection (a) who has a chronic condition specified in subsection (b) must be charged as follows:

(1) For an employee with a family income of at least three hundred fifty percent (350%) of the federal income poverty level, the employee shall pay one hundred percent (100%) of the premium for the association policy.

(2) For an employee with a family income of at least two hundred percent (200%) but less than three hundred fifty percent (350%) of the federal income poverty level, the employee shall pay twenty-five percent (25%) of the premium for the association policy.

(3) For an employee with a family income of at least one hundred percent (100%) but less than two hundred percent (200%) of the federal income poverty level, the employee shall pay ten percent (10%) of the premium for the association policy.

(4) For an employee with a family income of less than one hundred percent (100%) of the federal income poverty level, the employee shall pay two percent (2%) of the premium for the association policy.

The employee's employer shall pay the remainder of the premium for the association policy.

SECTION 3. IC 27-8-10-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 10. ~~Before January 1, 1996,~~ **(a)** The board of directors of the association shall, **subject to subsection (b),** establish eligibility guidelines for the issuance of an association policy under this chapter to prohibit an:

(1) employer;

(2) insurance producer; or

(3) insurance broker;

from placing in or referring to the association an individual who works for an employer who offers employees an employee welfare benefit plan (as defined in 29 U.S.C. 1002).

(b) The guidelines established under subsection (a) must allow for referral of an employee to the association for coverage as described in section 5.2(c) of this chapter.